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Program Relationships of Community Hospitals And Medical Schools in CME

Robert H. Younghouse, Jr., Ed.D., and William H. Young, D.Ed.

Abstract—In this paper, the authors report on a nationwide study that examined continuing medical education (CME) "programmatic linkages" between medical schools and community hospitals. Data were gathered to answer two major questions. To what extent are U.S. medical schools currently involved with community hospitals in providing cosponsored, accredited CME programs on an ongoing basis for hospital staffs? How do such programs differ one from the other? Data obtained indicated that a majority (70 percent) of the medical schools have CME programmatic linkages with community hospitals and that these relationships were viewed as very positive and beneficial.

For the past 50 years the literature has provided insufficient data on medical school/community hospital cooperation in continuing medical education (CME). Pioneering literature from the University of Michigan (1), Tufts University (2), and Albany Medical College (3) provided a base for action. Later studies at Stanford University School of Medicine (4), the University of Connecticut School of Medicine (5), Yale University School of Medicine (6), and the University of Southern California (7) provided more data concerning efforts undertaken by these institutions in conjunction with community hospitals. Authors such as Vollan (8), Freymann (9), Manning (10), Firestone and Howard (11), Bergin and Holmes (12), and Block (13) highlighted the importance of hospital-based continuing medical education and, to some degree, the need for close relationships between medical schools and community hospitals.

The purpose of the study reported here was to determine the extent of medical school/community hospital cooperation in cosponsored, accredited CME programs in community hospitals; to discuss how the programs differ in terms of procedures for planning and development, including needs assessment, faculty selection and involvement, teaching methodology, and evaluation; to determine the benefits of such cooperative educational programming; and to make recommendations for medical school/community hospital cooperation.

Methods

Following a review of the literature, the investigators undertook interviews with University of Illinois College of Medicine leaders in CME to prepare adequately a national survey instrument. Using de-

Dr. Younghouse is director, Office of Continuing Education, University of Illinois College of Medicine at Peoria, and Dr. Young is director for continuing education and public service at the University of Illinois at Chicago Health Sciences Center.

scriptive research techniques, the investigators then developed a survey questionnaire to collect data. Qualitative and quantitative data were requested via 21 forced-choice questions and two open-ended questions which required 15 to 30 minutes of response time.

The sample consisted of 123 deans or directors of continuing medical education at medical schools accredited by the Liaison Committee on Medical Education in the continental United States in 1981. The collection of data was completed in November 1982. Two mailings were utilized, and 92 completed questionnaires representing 75 percent of the sample were returned with usable data.

Data from questionnaires were analyzed on the basis of descriptive statistics. Forced-choice responses were analyzed quantitatively using frequency tabulations, measures of central tendency, and chi-square analysis.

Results

On the basis of the literature review, it was hypothesized that no more than 25 percent of the medical schools in the sample would have cosponsored, accredited CME programs with community hospitals that were ongoing and conducted in the hospitals.

However, an analysis of the data rejected that hypothesis. Seventy percent (64) of the individuals responding indicated that their respective medical schools had such a cooperative programming activity. Of the institutions represented, 70 percent were public, and 78 percent were located in a city where there were no other medical schools within a radius of 25 miles. The mean number of hospitals involved in cosponsored arrangements with individual medical schools was 11.8, ranging in distance from the medical school from less than one mile to over 75 miles.

Among the medical schools involved in this type of educational activity, there was a disparity regarding procedures for planning and developing the courses, assessment of physicians' educational needs, teaching methods, faculty selection and involvement, evaluation, benefits, and factors important in sustaining the "programming linkages" with the hospitals.

The typical cosponsored, programmatic activity as defined by the data was conducted on a monthly basis (30 percent), averaging one to two hours in length (70 percent). In 40 percent of the cases, the length of the activity was determined jointly by the community hospitals and the medical schools. In most cases (89 percent) the medical schools had administrative responsibilities for awarding credit for the programs. Full-time medical school faculty members were used more frequently (59 percent) as instructors than any other resource. A majority (64 percent) of faculty members were paid honoraria by community hospitals. A large majority (84 percent) of faculty members were also paid travel and other expenses by community hospitals. Lecture presentations dominated (77 percent) the instructional strategy utilized in presenting information to hospital medical staffs. Participatory methods were found to be least utilized (9 percent). On a scale of 1 to 5 (1 = never, 5 = always), needs assessment is usually (mean = 3.6; S.D. = 0.9) conducted by hospital CME committees making use of physician staff surveys. Responsibility for faculty selection was equally divided between medical school directors of continuing medical education (mean = 3.3; S.D. = 1.0) and community hospital directors of medical education (mean = 3.2; S.D. = 0.8). Post-program evaluations continued to monopolize the methodology used to evaluate the programs (mean = 4.1; S.D. =

0.9). Follow-up questionnaires were used occasionally (mean = 2.6; S.D. = 1.0); program pre-post tests or audits were seldom used (mean = 1.9; S.D. = 0.8).

The major benefit connected with cosponsoring programs was providing physicians with accredited CME activities in their own hospitals. Eighty-one percent of the sample judged this benefit to be "very important." The least important benefit was the additional sources of income for the medical school; 76 percent judged this as "not at all important" or "not very important" (Table 1).

The major factor in sustaining medical school/community hospital programming linkages was a commitment on the part of the hospital medical staff, This item on the questionnaire was designed to be answered by all respondents regardless of whether or not their medical schools had program arrangements with community hospitals. The data indicated that 73 percent of the respondents to this question had joint programs and that 27 percent did not. The commitment to cosponsored CME programming of the community hospital medical staff was judged to be "very important" by 79 percent of the respondents whose medical schools were involved in this kind of activity and by 61 percent of the respond-

TABLE 1

Mean Scores of 64 U.S. Medical School Deans or Directors of CME Responding to Questionnaire Indicating the Benefits of CME Programs Cosponsored by Medical Schools and Community Hospitals, 1982

Benefits	Mean*	S.D.
Provided physicians with CME credits in their own hospital	3.7	0.6
Fulfilled part of medical school's mission and goals	3.6	0.5
Provided communication link between medical school faculty and hospital physicians regarding patient care problems	3.6	0.6
Increased medical school's image and visibility	3.5	0.5
Provided cost-effective means of obtaining CME programs for staff physicians	3.3	0.6
Provided visibility to new medical school faculty members	3.1	0.9
Increased referrals to medical school's teaching hospital or clinic	3.1	0.8
Enabled hospitals to conform to JCAH standards†	3.0	0.7
Provided visibility to experienced medical school faculty	3.0	0.8
Improved teaching skills of medical school's faculty	2.3	0.7
Improved undergraduate and graduate teaching relationships	2.2	0.9
Increased joint medical school/community hospital research activities	2.2	0.9
Provided additional sources of income for medical school	1.8	0.8

* 1 = not at all important, 2 = not very important, 3 = somewhat important, 4 = very important.

† Joint Commission on Accreditation of Hospitals.

ents whose medical schools were not. The least important factor was distance to community hospitals from the medical schools. Nineteen percent of the respondents whose medical schools had joint programs indicated that this factor was "very important," compared with 35 percent of the respondents whose medical schools did not have such programs. Respondents by category judged six of seven factors as "somewhat" to "very important" in terms of mean averages (Table 2).

Discussion

This study was undertaken primarily because of a lack of information available in the literature regarding nationwide CME program linkages between medical schools and community hospitals. The major finding indicated that a majority of medical schools in the continental United States were involved in cooperative CME programs with community hospitals.

Medical school deans or directors of CME whose own institutions are not currently involved in this kind of educational activity and who wish to explore the possibilities of initiating such programs can start by disseminating and discussing information and publications about successful medical school/community hospital CME linkages at national, state, and regional continuing professional education meetings.

Based on the findings and implications of this study, as well as on literature sources, the following administrative model for cosponsored medical school/community hospital programming linkages is set forth:

1. Initial or continuing commitment. Medical school directors of CME should assess and continually reassess the commitment to cosponsored CME programming activities with community hospitals on the part of both faculty members and clinicians, since a major finding of the study indicated this factor was very important in sustaining or initiating these activities.

2. Needs assessment. A systematic effort on the part of continuing education providers to determine the educational needs of physicians through surveys, medical audits, interviews, and discus-

TABLE 2

Mean Scores of 86 U.S. Medical School Deans or Directors of CME Responding to Questionnaire Indicating Factors Important in Sustaining CME Programs Cosponsored by Medical Schools and Community Hospitals, 1982

Factors	Mean*	S.D.
Community hospital medical staff commitment	3.7	0.5
Community hospital administration commitment	3.6	0.5
Medical school faculty commitment	3.6	0.6
Medical school administration commitment	3.6	0.6
Medical school/community hospital relationships	3.5	0.5
Availability of other types of CME activities in hospital	3.0	0.7
Distance of community hospital(s) from medical school	2.9	0.8

* 1 = not at all important, 2 = not very important, 3 = somewhat important, 4 = very important.

sions should be undertaken. These educational needs are then translated into learning objectives. Data should be gleaned from community hospital physicians before any medical school faculty member becomes involved in the process of program development. Medical school deans or directors of CME whose needs assessment activities are medical school-based should reassess this portion of their program development strategy. Ideally, the community hospital is the logical focal point for the identification of needs. The medical school then becomes the educational resource for the community hospital to meet these needs.

3. Faculty selection and involvement. Faculty members should be selected by both the medical school and community hospital, but final approval for the faculty should rest with the medical school. Once this has been achieved, the faculty must work with the appropriate representatives of the community hospital medical staffs in the preparation of program content. This would enhance the degree of inter-institutional decision-making and communication typically missing from other CME programs which are conducted at remote sites by medical schools.

4. Teaching methodology. The study indicated that the most utilized method of instruction was live didactic presentations. Medical school directors of CME should take into consideration the fact that high technology delivery of CME is the wave of the future and should explore additional or alternative methods of remote program delivery through the use of teleconferencing, closed-circuit television, and computer programming systems that link the medical schools with outlying community hospitals. However, the instructional strategies should be based upon three major criteria: (*a*) faculty members' ability to use the technology or method involved, (*b*) community hospital physicians' preferred method of learning, and (*c*) cost-effective measures of program delivery.

5. Evaluation. The findings of this study show that postprogram evaluations continue to dominate program evaluation strategies. Medical school directors of CME should recognize the utility of follow-up questionnaires, pre-post program examinations, and pre-post patient review audits as viable and important evaluation tools. Evaluation methods should be determined jointly but remain the primary responsibility of the medical schools.

6. Financial responsibilities. The findings indicated that community hospitals are the primary financial source for payments of honoraria and travel expenses. Medical school directors of CME should reevaluate the financing arrangements of their cooperative programs with community hospitals if their schools provide the sustaining support for this kind of educational activity. This can be accomplished on an annual contractual basis or on a program-by-program basis.

The model described here demonstrates the need for extensive communication and decision-making on the part of the medical schools and community hospitals for the development and maintenance of high quality educational activities in community hospitals. As indicated by the findings, the benefits of this kind of joint arrangements were very advantageous to the medical schools, community hospitals, and, ultimately, physicians.

Continuing medical education for the physician must be considered a partnership between institutions which have a stake in health care. A linkage is required to join the needs for educational and professional growth of the individual physician with the educational and service delivery capacity of the medical schools

to provide better health care. The development and expansion of the kinds of CME programming activities described here together with the intervention of new instructional modes and strategies can provide this linkage.

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